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DOI: 10.35765/pk.2019.2401.06

The Effectiveness of Tools to Assess Training to Prevent Aggressive Behavior Towards Medical Staff in an Intercultural Perspective

ABSTRACT

Aggressive behavior poses a serious problem to medical staff. It has numerous consequences for the employees: they may experience anger, helplessness and even burnout, which ultimately affects the therapeutic process in a negative way. To reduce these negative consequences, a number of solutions are put forward, including training to prevent aggression. The content and programs of this type of training remain open, however, the literature recommends focusing on issues related

Suggested citation: Lickiewicz, J., Nag, T., Ravnanger, C., Majchrzak, A. i Makara-Studzińska, M. (2019). The Effectiveness of Tools to Assess Training to Prevent Aggressive Behavior Towards Medical Staff in an Intercultural Perspective. *Perspektywy Kultury*, 1(24), 51-69.

to preventing the occurrence of aggressive behavior. The training is intended to provide the staff with adequate knowledge of how to deal with the aggressive behavior of patients, although this is not the only effect. It also affects the attitudes and sense of self-efficacy of participants. The effectiveness of the training in this area is measurable. Appropriate tools are used to this end, provided by the trainers to the trainees. However, one should take into account the aspects of intercultural differences, such as different training systems, principles of patient care or education, which may condition the effects and changes resulting from training to prevent aggression.

KEYWORDS: aggression, staff-patient relationship, aggression management program, attitudes

STRESZCZENIE

Efektywność narzędzi do oceny skuteczności treningu zapobiegania zachowaniom agresywnym wobec personelu medycznego w perspektywie międzykulturowej

Zachowania agresywne stanowią poważny problem w pracy personelu medycznego. Mają one liczne konsekwencje dla pracowników; odczuwają oni złość, poczucie bezsilności, a nawet doświadczają wypalenia zawodowego, które ostatecznie wpływa w sposób negatywny na proces terapeutyczny. Zmierzając do ograniczenia negatywnych konsekwencji tego procesu, proponuje się wiele rozwiązań, do których należą treningi zapobiegania agresji. Treść i program tego typu szkoleń mają charakter otwarty, jednak literatura przedmiotu zaleca koncentrację na zagadnieniach związanych z przeciwdziałaniem wystąpieniu zachowań agresywnych. Treningi w założeniu mają na celu wyposażenie personelu w odpowiednią wiedzę dotyczącą zasad postępowania wobec zachowań agresywnych pacjentów, jakkolwiek nie jest to ich jedyny rezultat. Wpływają one także na postawy i poczucie własnej skuteczności uczestników. Efektywność treningu w tym zakresie jest możliwa do zmierzenia. Służą temu odpowiednie narzędzia, które prowadzący szkolenie może przekazać swoim kursantom. Należy jednak uwzględniać aspekt różnic międzykulturowych – inne systemy szkolenia, zasady opieki nad pacjentem czy też wychowanie mogą warunkować uzyskane efekty i zmiany, będące efektem treningu zapobiegania agresji.

SŁOWA KLUCZOWE: agresja, relacja personel-pacjent, trening zapobiegania agresji, postawy

1. The problem of aggressive behavior towards medical staff

The risks caused by aggressive behavior towards medical staff should not be marginalized. They pose a serious threat, affecting not only the safety of the employees, but also ultimately result in deterioration in the quality of health care. Facing aggression from patients and often also their families often causes negative consequences among the staff, which include: anger, frustration, helplessness or self-blame, and ultimately a negative attitude towards patients.[1] In extreme cases, it leads to absenteeism or change of jobs, or even complete leaving from health care. Another effect of chronic exposure to aggressive behavior of patients can also be burnout.[2] All of these factors ultimately result in deterioration of the quality of health care.

It is not surprising that various measures are taken to minimize the negative effects of such situations. These include organizing training to deal with aggressive behavior towards medical staff. Historically, the training focused mainly on physical aggression. The trainers did not try to investigate the essence of the motivations of aggressive behavior, believing that the most important point was to teach correct ways of practicing defense against the aggressive patient. This approach resulted in a change in the approach of staff towards their wards, causing excessive concentration on physical hazards, ignoring verbal aggression or preventing it.

Aggressive behavior can have different sources, such as mental illness, brain damage, the effects of psychoactive substances, intellectual disability, or extreme emotional arousal. The most commonly reported causes of patient aggressive behavior include pain and suffering due to illness, dependence on medical staff, frustration, insecurity, helplessness against the functioning of the health care system, long waits for medical attention, distant waiting times for treatment, helplessness in the face of disease, the plight of the patient or their severe anxiety.[3]

The factors affecting aggressive behavior of psychiatric patients include:

- external factors which relate to the physical properties of the ward, for example, overcrowding or lack of privacy;

1 E. Bimenyimana, M. Poggenpoel, C. Myburgh, V. Van Niekerk, *The lived experience by psychiatric nurses of aggression and violence from patients in a Gauteng psychiatric institution*,"Curationis" 2009, 32(3), pp. 4-13.

2 K.L. Edward, K. Ousey, P. Warelow, S. Lui, *Nursing and aggression in the workplace: a systematic review*, "British Journal of Nursing" 2014, 23(12), pp. 653-659.

3 H. Fiłończuk-Wieczorkowska, M. Żukrowska, *Przykłady zachowań agresywnych i sposoby radzenia sobie z agresywnym pacjentem*, in: A. Steciwko, J. Barański, A. Mastalerz-Migas, *Agresja w opiece zdrowotnej. Zagadnienia wprowadzające*, Wrocław 2014, p. 126.

- internal factors, i.e., the existing elements in the patient's past (however long they had struggled with the illness) at the time of admission to the ward, These include: psychosocial factors, such as elevated aggression as a way of solving problems inherited from the family of origin;
- situational and interactive factors, referring to how the patient perceives their status on the ward, If the nurse staff as those having some authority over the patient give them the feeling that they have no rights, therefore treating them with disrespect, the patients may respond with anger and rage. Similar emotions can arouse from the way the medical staff uses coercive measures.[4]

The above-mentioned risk factors can be further expanded with the following:

- elements associated with a disease state (productive symptoms, personality traits, age, sex, organic changes occurring in the central nervous system and somatic reasons);
- elements related to the ward functioning (its space, the number of patients per room, factors associated with the psychiatric staff);
- factors related to the interactions between the individual and environmental factors.[5]

As is apparent from the above, a large part of those factors depend on the staff, therefore adequate action and an attitude of respecting the dignity of the patient are important.

Staff often notes some problems that occur on their ward. These include: negative attitudes of staff, desire to restrict or control patients, and environmental aspects that cause tension to arise, e.g. overcrowding (and thus less staff per patient).[6]

An important skill in lowering tension is a technique referred to as de-escalation. It involves limitation or lessening of the intensity of aggressive behavior on the part of other people, including patients. De-escalation is seen as a valuable tool in the work of nurses which can help them to prevent aggression on the part of patients.[7] Its role as part of a therapeutic process is emphasized. Researchers define de-escalation as a solution in potentially aggressive situations through the use of verbal and physical

4 A. Bjorkdahl, *Violence prevention and management in acute psychiatric care. Aspect of nursing practice*, Stockholm, 2010.

5 D. Szcześniak, J. Rymaszewska, *Agresja pacjenta chorego psychicznie*, in: A. Steciwko, J. Barański, A. Mastalerz-Migas, *Agresja w opiece zdrowotnej. Zagadnienia wprowadzające*, op. cit., p. 81.

6 E. Walter, A. Hanson, R.B. Jr Flannery, *Risk factors for psychiatric inpatient assaults on staff*, "Journal of Mental Health Administration" 1994, 21(1), 24-32.

7 L. Cowin, R. Davies, G. Estall, T. Berlin, M. Fitzgerald, S. Hoot, *De-escalating aggression and violence in the mental health setting*, "International Journal of Mental Health Nursing" 2003, 12, pp. 64-73.

empathy, the pursuit of alliance and non-confrontational boundary setting, based on respect for the patient. Traditionally de-escalation is divided into verbal, when the nurse is not directly involved in the situation and may only use their voice to calm the patient (e.g. telephone conversation) and physical, which manifests itself through behaviors that can be seen even before the aggressive behavior occurs, for example, by adopting a relaxed and comfortable posture without intruding the personal space of an agitated person. Some authors do not accept this typology, explaining that this technique should be applied through a combination of verbal and non-verbal de-escalation, because only complementarity ensures its effectiveness.[8]

The aim of de-escalation is to prevent the occurrence of a violent incident. Improper use of this technique can result in mistrust on the part of patients and a sense of helplessness in the confrontation with staff. There is no place to build understanding and respectful relationships between staff and patients, if untrained ward employees do not know how to take care of it. The result may be a malfunctioning of the whole organizational system of the facility, as the lack of the ability to create an appropriate atmosphere and a sense of safety for patients may turn into aggressive treatment of staff. Thus, a vicious circle of violence may arise.

The staff's behavior towards the patient is an important message. It conveys information on whether he or she is treated subjectively or objectively, which in effect may intensify negative emotions and lead to aggressive behavior. A fully respectful and understanding approach should be adopted by medical staff in every interaction with other people. The fact that the patient is being treated does not authorize the doctors and nurses to objectification. Also, patients do not have the right to act out aggressively towards nurses and doctors. In such situations, the staff has the right to oppose the unacceptable behavior.

2. Aggression management training

In order to understand the many reasons why aggressive behavior occurs, it is necessary to understand the patient's motivation and the underlying causes of his or her health problems. Staff should also be expected to be able to reduce emotional tension and to act to deescalate aggression.

8 Ibidem.

James Wassell proposes three areas of intervention which can be combined according to the specifics of the aggressive incidents that the staff faces. He proposes the following types of change:

- environmental, such as illuminated entrances and exits, the use of safe computer equipment or other technical security measures (e.g. bulletproof glass in doors);
- organizational and administrative, including developing programs, principles and practices to promote a safe working environment (e.g. elimination of working alone on night shifts);
- behavioral/interpersonal, combining training in anticipation, recognition and responding to conflict and violence in the work place (e.g. management of violent incidents in health care).[9]

Aggressive behavior in the workplace is a widespread and dangerous phenomenon, carrying serious health consequences. The development of an incident in which a patient reacts aggressively to doctors or nurses depends largely on how the staff behaves. Different scenarios of behavior, attitudes and techniques are possible, on top of different ways of decreasing, or conversely, increasing tension. A key action in this respect is adequate education of staff, which should be based on training them in coping with and preventing aggression. This can be achieved through training in which staff learn to recognize the first signs of aggression in their patients or clients and effectively counteract them. Issues raised in the course should also cover situations where an aggressive incident has already occurred.

Such knowledge and skills cannot be acquired with work experience. This is why medical personnel need special training to deal with aggressive behavior. The idea of this type of training was formed already many years ago, initiated and developed within psychiatry. Violence on psychiatric wards has always been a serious problem. The common belief that all patients in a psychiatric ward exhibit aggressive behavior is, however, a mere stereotype.[10] Socially unacceptable behavior in this group of people is often associated with a previous criminal history, drug-induced psychosis or dementia.[11] Due to unpredictable patient behavior, psychiatric wards require a specific approach and special observation of patients and their what they do.

Education in this field allows us to understand the mechanisms that can direct people behaving aggressively. Understanding allows one to

9 J.T. Wassell, *Workplace violence intervention effectiveness: A systematic literature review*, "Safety Science" 2009, 47, pp. 1049-1055.

10 D. Szcześniak, J. Rymaszewska, *Agresja pacjenta chorego psychicznie*, op. cit., p. 81.

11 C. Mayhew, D. Chappel, *Workplace violence: An overview of patterns of risk and the emotional stress consequences on targets*, "International Journal of Law and Psychiatry" 2007, 30, pp. 327-339.

approach the patient or client in a calm way, which increases one's ability to control an aggressive situation and makes it possible to prevent it in the future. Training can make medical professionals aware of whether their perception of violence and the interventions they take in a given situation would help them in reality and prevent it from happening again or not. It also provides information on how to deal with situations where staff members have contact with aggressive people. Only effective coping with aggression and preventing its occurrence allows one to reduce its frequency and the associated risks. However, the most important skill is not dealing with existing conflict, but knowing how to prevent it.

Training in this field should be mandatory, as the safety of health care employees is a top priority. The key element is to answer the question what the training should be about and what content it should cover. Properly designed training should be based on the latest theoretical knowledge and involve all staff, regardless of function. Among the issues discussed, guidance should be expected in relation to staff selection, work design and organization, risk factors, principles of situation assessment, post-incident action and methods of containing aggressive behavior.[12] According to the Health Services Advisory Committee, a properly structured program requires three groups of action to eliminate aggressive behavior in working environments. These are: problem investigation, risk assessment and risk reduction methods. An additional element is an indication of what has been done to reduce risk. According to these guidelines, training is regarded as the most important element in reducing the risk of aggression, in conjunction with the reorganization of the working environment and providing safety.[13]

Training individuals in aggressive behavior management consists of developing their social and interpersonal skills helpful in soothing and preventing dangerous situations. This applies mainly to the person's professional role at the ward. The training is intended to increase the ability to recognize aggressive people and situations. It also helps create competent and specialized staff, ready to bear responsibility for more complex interactions. Employees should acquire knowledge about the nature of aggressive patient behavior and the such patients' motivations. It is also advisable to teach skills to recognize signals of aggressive behavior and to know how to react in such situations.[14]

12 M. Chappell, *Violence at work* (second edition), International Labour Organisation, Geneva 2000.

13 B. Beech, P. Leather, *Workplace violence in the health care sector: A review of staff training and integration of training evaluation models*, "Aggression and Violent Behavior" 2006, 11, pp. 27-43.

14 M. Chappell, *Violence at work*, op. cit.

Beale et al.[15] suggest that adequate training focuses on prevention, calming and negotiation skill, not on confrontation. A training program should consist of modules containing guidelines for action ranging from basic care for the client/patient and dealing with so-called difficult clients, to training in physical aggression containment. It should also include information on the motivation of aggressive behavior. Another important element is knowledge of risk reduction, anticipating violence, resolving aggressive situations, and managing then after aggressive incidents. The control of one's own emotions connected with an aggressive situation is also stressed as is the ability to understand normal and abnormal post-traumatic reactions, indicating the emergence of long-term negative effects of aggressive behavior.

The English National Board for Nursing, Midwifery and Health Visiting (ENB) indicates some issues that they believe should appear in the training These include prevention and management of violence, assertiveness techniques, tension relief techniques, communication skills, support, post-incident management and reporting. In addition, they should also include self-awareness, ethical and legal issues, understanding of violence and aggression as a reaction to events, reactions and positive attitudes towards other people.[16]

One of the training courses for preventing and managing aggression is TERMA. It was created over 20 years ago at Haukeland University Hospital, in the Department of Forensic Psychiatry in Bergen, and consists of issues relating to the theory of aggression, understanding the emotional and physical causes of aggression, identifying one's own thought patterns in response to a situation, and the risk factors of violence in the hospital. In addition, as part of the course, participants become familiar with legal issues, ethics and the role of teamwork in responding to aggression. The course also includes elements of physical self-defense and mandatory periodic repetition of the material.

Methods used by the trainer during the course include lecture, discussion, verbal and non-verbal communication on boundary setting, identification of caring and non-caring attitudes, methods to regain self-control and principles of coercive intervention as safe and well-organized along with body relaxation, in which practical training methods and role-playing are used.[17]

TERMA is not the only proposal of a course to deal with aggressive behavior. There are many programs that train medical staff in effectively preventing and dealing with aggression in the workplace. Not every one

15 B. Beech, P. Leather, *Workplace violence*, op. cit.

16 Ibidem.

17 J. Lickiewicz. *Skuteczność programu zapobiegania agresji w grupie studentów kierunków medycznych*, "Edukacja Ustawiczna Dorosłych" 2017, 3, pp. 157-165; A. Bjorkdahl, *Violence prevention*, op. cit.

of them focuses on the same aspects. Farrell and Cubit developed a list of 28 training programs for nurses and pointed to their most important aspects. Most of the programs focused on the cause of aggression (23 training courses), followed by communication skills (22 out of 28 programs), and 20 programs included physical techniques to prevent aggression, risk assessment, and legal issues. Data on the type of violence and leadership in a crisis situation were discussed in fifteen programs, while fourteen included information on teamwork and post-incident reports. A small number of the courses refer to the orientation in a situation about which we can get information in reports or rules of conduct in a ward/facility or an environment, which was highlighted in only nine curricula. Only seven training programs included pharmacological methods of dealing with aggression and physically holding the patient, while the costs incurred by employees due to aggression and isolating the patient in relation to his or her behavior were discussed in only four programs.[18]

The meta-analysis discussed above shows that the most important role in training is played by soft skills and understanding the motivation behind aggressive behavior. The physical aspects of coping and pharmacological methods play a marginal role. The open question is to what extent self-defense methods or the use of coercive measures should be omitted in such courses. There are situations in the work of medical professionals where the above-mentioned methods must be used, and when this happens, they should be used according to ethical considerations and respect for the patient. Risk factors for the occurrence of aggression and motivation were also one of the most popular topics of training. This is a very important issue, as medical staff should be aware of what to avoid in order not to provoke patients. In the case of patients on psychiatric wards, attitudes and actions of the staff are a very sensitive matter and are easy to misinterpret by patients. From the patients' perspective, the ward environment may turn out to be unpredictable, therefore the patient's communication with the medical staff is extremely important and gives a prospect of good cooperation.

Unfortunately, not all training courses discussed the issue of assessing the risk of violence, which is an important aspect, as without a full insight into the whole situation in which the employees find themselves, it is not possible to effectively counteract potential risks. Important (and rarely discussed) issues should include appropriate after-incident reports, as staff should be able to comment on difficult and threatening situations. This applies both to people who were involved and those who were

18 G. Farrell, K. Cubit. *Nurses under threat: A comparison of content of 28 aggression management programs*, "International Journal of Mental Health Nursing" 2005, 14, pp. 44-53.

the witnesses. Post-incident meetings are one of the methods to prevent burnout.

The effectiveness of this type of training is an open question. One staff study showed a statistically significant difference in the perception of patient aggression in groups of nurses who participated in an educational training focusing on aggression and groups that did not participate in it.[19] Similar results were obtained in studies of medical students, showing changes in their perception and attitudes towards aggressive behavior. Another effect of training in the examined group was an increase in the sense of self-efficiency and self-confidence. The results of the above studies indicate that training, in addition to the transfer of knowledge and skills, strengthen and develop the sense of self-efficacy.

Training should make medical staff aware of the importance of safety in the workplace and the impact that the workers themselves have on it. Research results, however, are not unambiguous. Hahn et al. have shown that aggression prevention training has not affected nurses' attitudes and has not changed their perception of aggressive behavior. There were also no significant differences in their way of coping with violence.[20] There is no doubt that trainings should give participants knowledge of the methods to react and prevent aggression, on top of awareness which ones to use (and when), as they should not be used as they see fit, but as appropriate to the situation. For this reason, training focuses mainly on knowledge, but it may also affect the attitudes and perception of aggressive behavior.

This raises the important question concerning the assessment of the effectiveness of this type of training. The basic goal is the skills expected of the participants after the course. If the training concerns only technical skills, the only condition is that the trainers have mastered the appropriate techniques and ways of dealing with physical aggression. Studies show that the effectiveness of training focusing exclusively on the aspects of self-defense, without periodic repetitions, is characterized by low efficiency.

3. Tools for assessing incidents of aggression

Modern aggression prevention training methods involve equipping medical personnel with much more than self-defense skills. The training cover

19 M. Lepiešova, M. Tomagová, *Analysis of The MAVAS Instrument to Assess The Management of Patient Aggression*, "Central European Journal of Nursing and Midwifery" 2014, 5(3), pp. 127-135.

20 S. Hahn, I. Needham, C. Abderhalden, J. Duxbury, R. Halfens, *The effect of a training course on mental health nurses' attitudes on the reasons of patient aggression and its management*, "Journal of Psychiatric and Mental Health Nursing" 2006, 13(2), pp. 197-204.

issues from the areas of law, motivation psychology, neurology or social communication. It can therefore be assumed that the training should also have an impact on the mental wellbeing of the participants. This applies to the attitudes and perceptions of aggressive behavior.

There is also the question of how to measure these skills. Among the many tools used to assess attitudes, those focusing on the impact of training on the attitudes of health professionals have not yet been proposed. However, it seems that in such situations, tools can be useful to assess attitudes and perceptions of aggression, assuming that they change under the influence of training.

One such method is the ATAS (Attitude Towards Aggression Scale). It is a tool used to evaluate the perception of aggression by medical staff. It is used to measure individual attitudes towards aggression. The scale contains 18 items, which include statements regarding various aspects of aggression. Each answer is given on a Likert scale. The theoretical basis for the creation of this method was the Theory of Planned Behavior by Ajzen.[21] According to it, there is a relationship between the attitudes and behavior of the individual. This assumption is in line with the goals that are set in training to deal with aggressive behavior. The theoretical aim of the ATAS was to assess what attitudes of nurses accompany the aggression of patients and to identify personal and environmental factors that affect them. The practical effect of the study was to construct a tool to measure attitudes towards aggression, which could be used to monitor aggression management.[22] The tool itself was created mainly on the basis of the definitions of aggression provided by the respondents, with little reference to the literature. The study that initiated the existence of ATAS was an analysis of the perception of aggression by nurses performed in five countries. As a result of factor analysis, five factors were obtained. It results from it that aggression was seen as:

- unpleasant and unacceptable: the statement that aggression is unnecessary, unpleasant and repulsive, spoils the atmosphere in the ward and makes treatment more difficult; and that its every form is always negative and unacceptable;
- communicative: aggression is treated as a signal aimed at improving the therapeutic relationship: the source of new opportunities for care; a situation that helps staff to get know the patient's other side; it can also be the beginning of more positive relations;

21 I. Ajzen. *The theory of planned behavior: reactions and reflections*, "Psychology & Health" 26.09.2011, pp. 1113-1127.

22 G.J. Jansen, T. Dassen, P. Moorer, *The Perception of Aggression*, "The Attitude of Nurses towards Inpatient Aggression in Psychiatric Care" 2005, 11, p. 55.

- destructive: aggression is the result of a patient experiencing strong emotions, which lead him or her to harming themselves or others; violent behavior towards others may cause damage to objects in the environment;
- protective: protecting the physical and emotional space of the patient;
- invasive: the intent of an aggressive patient is to destroy or damage something; aggression is an impulse which interferes with integration; it aims to dominate someone or harm them; it is expressed consciously with the exception of the behavior in people with psychotic disorders; it is non-adaptive.

The authors of the tool distinguished two groups of aggression's functions: communication and protection, perceived as carrying positive energy; and offense, destruction and intrusion, as signs of a negative perspective of aggressive behavior. It was also pointed to the negative correlation between these factors. The authors perceive the factors obtained as an extension of the previous research by Jansen.[23] A factor of aggression perceived as harmful was distinguished, containing three scales: offensive (unacceptable behavior), destructive (physical aggression without assessment) and intrusive (desire to hurt or dominate). The Polish adaptation of the tool, which is currently underway, confirms the results obtained earlier, indicating the existence of three or two subscales, depending on the ward where the staff worked.

Another tool that can be useful in assessing the effectiveness of training to prevent aggressive behavior is the POAS (Perception of Aggression Scale) questionnaire. The Polish version of this method contains 12 questions. The tool has the form of statements that begin with "Aggression is..." The respondent applies a scale from 1 to 5 ranging from "strongly agree" (1) to "strongly disagree" (5). In various world studies, various combinations and numbers of subscales were obtained, however, they always oscillated between two or three.[24] The resulting factors apply to aggression perceives as behavior which is: dysfunctional and unacceptable, understood and functional, and protective.[25] Importantly, the results proved to

23 G. Jansen, T. Dassen, P. Moorer, *The perception of aggression*, "Scandinavian Journal of Caring Sciences" 1997, 11.1, pp. 51-55.

24 H. Bilgin, N. Keser Ozcan, Z. Tulek, F. Kaya, N.E. Boyacioglu, O. Erol, K. Gumus. *Student nurses' perceptions of aggression: An exploratory study of defensive styles, aggression experiences, and demographic factors*, "Nursing & Health Sciences" 2016, 18(2), pp. 216-222; T. Palmstierna, E. Barredal, *Evaluation of the Perception of Aggression Scale (POAS) in Swedish nurses*, "Nordic Journal of Psychiatry" 2006, 60(6), pp. 447-451.

25 J. Lickiewicz, K. Sałapa, Z. Musiał, M. Dzikowska, *Skala postrzegania agresji wobec personelu (POAS) – adaptacja polska*, „Pielęgniarstwo Polskie" 2017, 67(1).

be sensitive to training designed to educate in coping with aggression that the respondents participated in.[26]

Another tool previously used to assess the effectiveness of aggression prevention training for medical staff is the MAVAS (The Management of Aggression and Violence Scale). The scale consists of 30 statements concerning internal and external conditions of aggression and violence from psychiatric patients, on top of methods for dealing with violent incidents against hospital staff. The participants respond to the individual statements by selecting their answers from "strongly agree," "agree," "disagree" and "strongly disagree."[27] According to the theoretical concept underlying the tool, there are three models of justifying aggression by medical staff investigated by the MAVAS:

- internal, associated with factors inherent in the patient, such as mental illness or personality traits. This model does not associate staff with responsibility for aggressive behavior of patients;
- external, looking at causes in the social environment, which may include the conditions and rules applied in the facility. Risk factors include overcrowding or atmosphere in the ward, the gender of the staff or their work experience;
- interaction and situation, emphasizing the importance of staff behavior and patients' mutual influence on each other. This model takes particular account the staff's communication style.[28]

The approaches to the prevailing atmosphere in the facility affect the final element associated with coping with aggression on the given ward.

The MAVAS was used in studies on the effectiveness of training to prevent aggression in a group of nurses, but did not obtain statistically significant changes in the attitudes of the participants.[29] Work is currently underway on the Polish version of this tool.

Another tool is a method that examines the attitude strictly related to the necessity of direct coercion by medical staff. It is the SACS (Staff Attitude Coercion Scale). The questionnaire was developed in Norway in order to measure the attitudes and thoughts of employees of medical facilities on the use of coercion in mental health care. The questionnaire has

26 S.C. Arguvanli, N. Karatas, M. Baser, *Effect of aggression management training program on knowledge and attitudes of nurses working at psychiatric clinics*, "Anatolian Journal of Psychiatry" 2015, 16.5, pp. 323-328.

27 J. Duxbury, S. Hahn, I. Needham, D. Pulsford, *The Management of Aggression and Violence Attitude Scale (MAVAS): a cross national comparative study*, "Journal of Advanced Nursing" 2008, 62(5), pp. 596-606.

28 S. Hahn, I. Needham, C. Abderhalden, J. Duxbury, R. Halfens, *The effect of a training course*, op. cit.

29 Ibidem.

been well received by health care professionals because it is quick to complete and easy to understand. Based on examination of relevance, the psychometric properties and clinical experience, the theory of five dimensions was discarded and a model of three was accepted.[30] The questionnaire has 15 items and the answers are contained in the 5-point Likert scale. The three subscales represent three different groups of attitudes among medical staff:

- coercion as a violent attitude: this view treats coercion as an offensive attitude towards patients. This dimension consists of six elements representing the most critical attitude towards the use of coercion and focuses on the desire to reduce it. Other aspects deal with that coercion is potentially harmful to people against whom it is used and violates the relationship between the caregiver and the patient;
- coercion as a form of care and ensuring safety: this view treats coercion as helpful in providing care and protection. This dimension consists of six elements, which focus on the use of constraint for safety reasons. Such an attitude can be considered a pragmatic approach to the use of coercive measures;
- coercion as a form of treatment: according to this attitude, coercion is an intervention used in treatment. This dimension consists of three questions representing the most positive opinion on the use of coercion. They show that the use of pressure is needed when a patient has no insight into his or her illness.[31]

It should be noted that the subscales obtained are related to the attitudes of staff a particular country, which may depend on legal regulations related to the legitimacy of using direct coercive measures by medical personnel. Therefore, this tool can be particularly sensitive to cultural factors. Currently, the Polish adaptation tool is underway.

The last of the proposed tools is the scale of self-confidence in dealing with aggressive patients (Confidence in Coping With Patient Aggression Instrument), which examines the level of confidence in dealing with patients manifesting aggressive behavior. The method consists of 10 questions in which the respondent makes a subjective assessment of their confidence in situations of confrontation using a scale of 0 to 10, where: 0 corresponds to a total lack of confidence, and 10 to a high degree thereof.

30 T.L. Husum, A. Finset, T. Ruud, *The Staff Attitude to Coercion Scale (SACS): Reliability, validity and feasibility*, "International Journal of Law and Psychiatry" 2008, 31, pp. 417-422.

31 T.L. Husum, J.H. Bjørngaard, A. Finset, T. Ruud, *A cross-sectional prospective study of seclusion, restraint and involuntary medication in acute psychiatric wards: patient, staff and ward characteristics*, "BMC Health Services Research", 6 April 2010.

The tool was first used in the research of confidence in contact with aggressive patients before and after the training. A statistically significant change was showed in the sense of confidence of people participating in the training, compared to those who did not take part in it. It was a long-term effect, since it remained even after eighteen months after the conducted training.[32] Another study evaluated the impact of participation in a training course on self-esteem and self-confidence for nursing students. The results were similar to the previously discussed ones.[33] The scale was also used in the study of the perception of personal safety and confidence in working with aggressive patients in the group of staff in forensic psychiatry. The respondents described their work environment as a safe place, and their ability to deal with aggressive behavior as a high.[34]

The above discussion does not exhaust the whole repertoire of tools that can be used to assess the effectiveness of aggression prevention training. The selection criterion was an earlier use of the method in evaluating training effectiveness. The process of analyzing the phenomena related to dealing with aggressive behavior is dynamic and as such will be subject to constant changes and modifications.

4. Conclusions

The considerations presented above clearly indicate the need to counteract aggressive behavior encountered by medical staff. This should be a thoroughly considered activity, focused on teaching staff the skills to prevent, not to deal with already existing situations. This means that training should focus on soft competence, including communication skills and the ability to de-escalate aggression. Analyses of previous research conducted in this area clearly indicate the impact of such training on the sense of security in medical staff and their confidence in dealing with aggressive behavior. In addition, they show that aggression prevention training also influences the participants' attitudes. The results in this respect are inconclusive. We should ask what issues raised in the training are and place

32 M. Thackrey, *Clinician confidence in coping with patient aggression: Assessment and enhancement*, "Professional Psychology: Research and Practice" 1987, 2:18(1), pp. 57-60

33 I. Needham, Ch. Abderhalden, A. Zeller, T. Dassen, H.J. Haug, *The Effect of a Training Course on Nursing Students' Attitudes Toward, Perceptions of, and Confidence in Managing Patient Aggression*, "Journal of Nursing Education" 2005, 8:4, pp. 15-20.

34 M. Trish, M. Daffern, *Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting*, "Journal of Psychiatric and Mental Health Nursing" 2006, 2(13), pp. 90-99.

particular emphasis on some of them. Currently, it remains open what the impact of the subject matter is along with the physical self-defense and de-escalation on staff attitudes. It can be assumed that focusing on the issues of physical self-defense without other aspects could negatively affect the image of the patient as an aggressive person who is ready to attack, not a partner in a relationship. This stereotype would have negative consequences for the whole treatment process.

Another problem is to evaluate the effectiveness of training. The possibility of obtaining different results from those expected should be taken into account. Explaining this situation requires an analysis of the construction of individual items and comparing them with the course assumptions. The primary objective of training is to provide the staff with knowledge about proper rules of conduct in case of aggressive behavior from a patient. Usually the curriculum of the course includes theories of aggression, and indicates situations in which staff intervention is necessary. In this context, staff may treat aggressive behavior as negative and unacceptable, although they will also understand the multiple motivations behind this type of acting out.

When using a tool in training assessment, one needs to be aware of intercultural differences as well. Health care and education systems for medical staff are not the same in different countries. This means that the initial attitude before training may be different depending on the health care system or the modality according to which future medical staff are educated. For this reason, the tool may give different results when used in different countries. This is due to the fact that attitudes are sensitive to social influence.[35] This makes it impossible to create a single overall pattern of expected responses in the case of the training applied and to measure the participants' progress in different countries.

However, there is an undeniable need for training in how to deal with aggressive behavior towards medical personnel. Knowledge of de-escalation of aggression directly affects the sense of security and quality of care for the patient. In conclusion, the question should not be asked "whether to provide training," but above all, how to do it.

35 R.J. Crisp, R.N. Turner, *Psychologia społeczna*, Warszawa 2015.

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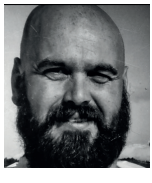

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